Comments on Kentucky's 1115 Medicaid Waiver Application

Kentucky Voices for Health is a coalition of more than 200 consumer advocacy groups, healthcare organizations, and individuals working to improve the health of ALL Kentuckians. We believe that the best healthcare solutions are found when everyone works together to build them.

As health advocates who have worked hand-in-hand with state agencies, providers, kynectors, legal aid programs and others across the Commonwealth to get Kentucky covered, we are proud of Kentucky's success and the difference coverage is making in the lives of more than 440,000 Kentuckians.

With the health and wellbeing of nearly half a million Kentuckians at stake, we find it alarming that Governor Bevin has vowed to end Medicaid expansion if the U.S. Department for Health & Human Services does not approve the Kentucky HEALTH plan. We strongly urge Governor Bevin not to put the health and economic security of our Commonwealth at risk. Medicaid expansion is working for Kentucky and we must take steps that build on that success.

As consumer advocates, we believe it is imperative that there be meaningful stakeholder input to ensure that the 1115 waiver is designed to meet the unique needs of Kentuckians and improve access to critically needed healthcare services for our most vulnerable citizens. The following comments have been prepared with direct input and support from well over 1000 Kentuckians as well as a number of our member organizations, including:

Advocacy Action Network
American Lung Association
Campaign for Tobacco-Free Kids
Catholic Conference of Kentucky
Cumberland Family Medical Centers
Fairview Community Health Center
Family Health Centers
Friedell Committee
Greater Louisville Reentry Coalition
Health Reentry Coalition of Kentucky
Kentuckians for the Commonwealth
Kentucky Center for Economic Policy
Kentucky Coalition Against Domestic Violence
Kentucky Council of Churches
Kentucky Equal Justice Center
Kentucky Housing & Homeless Coalition
Kentucky Primary Care Association
Kentucky Psychological Association
National Multiple Sclerosis Society
Shawnee Christian Healthcare Center

We appreciate this opportunity to provide feedback on Governor Matt Bevin's proposed 1115 Medicaid waiver called Kentucky HEALTH. We submit our comments with the hope federal regulators will listen closely to the needs and concerns of Kentuckians and work collaboratively with the Governor as well as other stakeholders in Kentucky to design a final proposal that will truly move Kentucky's health, economy and quality of life forward.

SUMMARY

Kentucky Voices for Health believes ALL Kentuckians deserve access to high quality, affordable healthcare, regardless of their circumstances. We view coverage as the essential *foundation* for better care, better health and better value. Medicaid expansion has given Kentucky an unprecedented opportunity to build that foundation and it's working.

Governor Bevin's proposed 1115 Medicaid waiver puts Kentucky's successful Medicaid expansion and the coverage of nearly HALF A MILLION Kentuckians at risk. It will mean less coverage and more barriers for the most vulnerable Kentuckians, including veterans, people with disabilities, formally resettled refugees fleeing persecution, low-income workers and families. This plan threatens to undermine the health and economic gains we have made in the past two and a half years as a result of Medicaid expansion. It would be a giant step backward for Kentucky.

The purpose of an 1115 waiver is to demonstrate that Kentucky can provide better access and better care than we are already doing. Therefore, any proposed changes should build on the success of Kentucky's Medicaid expansion to increase access to care, improve health outcomes, and create system efficiencies.

Our job as consumer advocates is to ask the same questions that we hope HHS will be asking as negotiations begin: Will the proposed reforms improve the health of Kentuckians? Will this proposal reduce barriers to care? Will this demonstration build on Kentucky's successful Medicaid expansion and the tremendous health gains we've made over the past two and a half years?

Our answer to all of these questions is an unequivocal "no". Kentucky HEALTH does not meet the criteria set forth by the Centers for Medicare and Medicaid Services (CMS) under Section 1115 to increase access, improve health and create efficiencies. To the contrary, it will:

- Eliminate coverage for an estimated 88,000 eligible Kentuckians and potentially many more who will be unable to meet the new requirements or understand complex system changes.
- Penalize hard-working, low-income Kentuckians and their families.
- Put more burden on our most vulnerable citizens.
- Create significant financial and administrative barriers to care.
- Reduce access to medically necessary services.
- Expand bureaucracy with increased administrative cost and red tape.

As the federal comment period comes to an end and negotiations between HHS and Kentucky begin, we strongly urge Governor Bevin and federal regulators not to put the health and economic security of our Commonwealth at risk. Medicaid expansion is working for Kentucky. We must take steps that build on our success to move Kentucky's health, economy and quality of life forward.

THE VALUE OF EXPANDED COVERAGE & WHAT KENTUCKY STANDS TO LOSE

Members of Kentucky Voices for Health (KVH) participated actively in each of the three hearings held during the state comment period in Bowling Green, Frankfort and Hazard. At each, we were surprised and dismayed to hear Secretary Glisson say repeatedly that Medicaid coverage - and the Medicaid expansion in particular - has not "moved the needle" on Kentucky's health. We respectfully disagree. The impact of expanded coverage has been tremendous.

Kentucky leads the nation in the decrease in our rate of uninsured, dropping from 20.4 percent in 2013 to 7.5 percent in 2015. This translates into nearly 440,000 Kentuckians gaining affordable coverage - many for the first time in their adult lives. Coverage alone is not the end goal. It's the foundation for better care, better health and better value.

Dr. Eli Pendleton has witnessed the impact first-hand as a family practice physician in Louisville, saying that patients came "to me with tears in their eyes, overjoyed that they were finally able to take charge of their health problems. I had people quit smoking, get their blood pressure and diabetes under control, get much needed glasses, and finally address long-standing dental issues. Many of these patients were then able to rejoin the work force, often enthusiastically…"

For all of these reasons, we cannot afford to lose the gains we have made in terms of Kentucky's health and our economy. Below are a few of the many ways that ALL Kentuckians benefit, including those with Medicaid coverage as well as employers, healthcare providers, and taxpayers.

Covering low-income workers, caregivers and students
The majority of Kentuckians who benefit from Medicaid expansion are working adults in low-wage jobs. The majority of those who aren't working outside of the home are caregivers or students.

Improving health
In 2014 ALONE preventive screenings for diabetes, cholesterol, and cancer DOUBLED. Trips to the emergency room in Kentucky decreased by 3%. The share of low-income Kentuckians with chronic conditions receiving regular care has increased by 15%. Tens of thousands more Kentuckians are benefiting from early detection, treatment and disease management. And that's good for all of us. Their ability to go to the doctor when they get sick means the rest of the state can stay healthier.

Strengthening families
Medicaid coverage for parents, in particular, has meant that more kids are getting enrolled in coverage and getting the care they need for a healthier future. And it means that parents have the peace-of-mind and security they need to be better parents. They can finally take care of their own health issues –which many have had to ignore in the past – and they are more financially secure, knowing that a medical problem isn't going to lead to bankruptcy.

Investing in our healthcare providers and expanded services
Expanded coverage means more payments to providers and less uncompensated care. In 2014-15, Medicaid providers received more than $3 BILLION in additional revenue. This was further bolstered by a similar decrease in uncompensated care. By the beginning of 2015, this has translated into an increase in over 13,000 jobs in the healthcare and social services sector as well as a significant expansion of services, particularly in greatly needed areas, such as school-based health, behavioral health, substance use treatment and oral health.

Helping employers
A healthy workforce is a productive workforce, which helps businesses and local economies grow. Businesses have also directly benefited from the infusion of more than $1.5 billion annually into Kentucky's economy due to expanded coverage.

Creating more value for taxpayers
Decreases in uncompensated care are being further bolstered by increases in tax revenue. Kentucky's biennial budget has benefited from an additional $300 MILLION in tax revenue directly related to Medicaid expansion, while saving $265 MILLION from shifting the cost of safety-net and charity care

programs to Medicaid reimbursable services. Add to this the increase in local tax revenue that is now being invested in every community across the Commonwealth and it becomes clear that Kentucky simply cannot afford to lose expanded coverage.

KENTUCKY HEALTH ELIGIBILITY

The Kentucky HEALTH plan states that the program is designed for "able-bodied", working age adults and their families. Underlying this proposal is an outdated sense of paternalism. The plan implies that low income Kentuckians aren't already interested in their health, engaged in their communities, and contributing meaningfully to our economy.

Kentucky HEALTH is designed on the assumptions that: 1) low-income Kentuckians covered under the Medicaid expansion are not working; and 2) individuals who are unemployed have chosen not to work. We disagree with these assumptions. First, U.S. Census data tells us that more than half of Kentuckians eligible for Medicaid expansion are working, while the majority of those not working are caregivers or students. Second, the number of available jobs - in particular those that would move an individual or family above 138% of the Federal Poverty Level - are lacking in many parts of the state, making it difficult for many Kentuckians to find or maintain employment.

It is misguided to treat Medicaid as a Welfare program that creates dependency for "able-bodied" adults. To the contrary, Medicaid coverage KEEPS Kentuckians working, helps parents get healthy and stay healthy so they can be better parents, and gives kids a healthy start so they can reach their potential. Access to care without barriers helps to break the cycle of poverty.

Medicaid is a safety-net program for low-income individuals and families. It is neither appropriate nor productive to create separate classes of the deserving and undeserving poor. Instead, Kentuckians would be better served by policies and programs that recognize and address the numerous barriers low-income individuals and families face in finding and maintaining gainful employment.

Finally, we are concerned that Kentucky HEALTH is designed for the "able-bodied" expansion population, but also includes children, pregnant women, parents and caretakers, those on transitional medical assistance, and those considered "medically frail". While the plan states that this is intended to provide more seamless coverage for entire families, we are concerned that there will be unintended consequences. New system requirements and added complexity would create more barriers for all eligible Medicaid members.

Community engagement and employment requirements

Increasing employment among low-income Kentuckians is a laudable goal of Governor Bevin's and one we share. However, transforming Medicaid into a jobs program would be counterproductive. Access to care for vulnerable populations *improves* their ability to work. Placing additional requirements and penalties on low-income Kentuckians as a condition of qualifying for or maintaining Medicaid coverage will only serve to reduce the number of those enrolled in coverage, making it more difficult for them to find and maintain employment.

It has long been demonstrated that work requirements in other safety-net programs are not only ineffective at promoting long-term employment and wage growth, but keeps many in a cycle of deep poverty.

Additionally, the proposed work and volunteer requirements would add a significant amount of administrative cost and burden to an already overwhelmed and fragmented system. Neither the Department for Medicaid Services nor the individual Managed Care Organizations have the existing infrastructure or staff capacity to track and manage these requirements effectively.

Furthermore, it is unrealistic to expect local governments and nonprofit organizations to develop the necessary jobs and volunteer positions to carry out the mandates of this program without significant support. This plan does not take into account the cost of job development, background checks, training, supervision, liability or the additional administrative burden of tracking and reporting these activities. During the state comment period, members of the Kentucky Nonprofit Network voiced concerns that the community engagement requirement would be a burden on their organizations.

Moreover, we find it troubling that Governor Bevin has proposed work and volunteer mandates that are not approvable. CMS has made it clear that states may not limit access to coverage or benefits by conditioning Medicaid eligibility on work or other activities.

Projected Enrollment

The purpose of 1115 Medicaid waivers is to test ways to expand coverage or to otherwise improve care, not to move backwards on health care access. For that reason, we are gravely concerned by the projected decrease in enrollment of the five-year demonstration period and expect that many more could lose coverage or experience severely limited access to care as a result of the proposed changes.

The proposed change to the current effective date is more administratively complex and would create a significant barrier to coverage. Extensive research has shown that premiums are largely unaffordable for the Medicaid population, leading the significant reductions in coverage and access to care. For this reason, we can expect that many Medicaid members with incomes at 100% FPL and below will experience a delay of approximately 60 days and will then be subject to unaffordable premiums for at least 6 months. While those with incomes above 100% FPL will face a similar delay if they cannot pay their premium at the time of application or will simply be unable to enroll if they are unable to pay their premium by the end of the 60-day period. Both of these scenarios are counter to the purpose and stated goals of the Medicaid program and to the waiver demonstration criteria.

The proposed elimination of retroactive eligibility would further reduce access to care and shift a significant burden to safety-net providers who are already operating with fewer and fewer charity care dollars. This is especially unwise in light of the recent benefind debacle in which thousands of Kentuckians lost coverage and tens of thousands more were at risk of losing coverage due to a system failure. At that time, the Administration asked providers to continue seeing Medicaid eligible members even while they were disenrolled, with the promise that providers could bill retroactively. If this eligibility is eliminated, providers would either take on the financial burden of providing uncompensated care to their patients or would be forced to turn them away.

With the transition from kynect to benefind and healthcare.gov currently underway, there is no reason to believe that a system failure won't happen again. In the case of many refugee benefit-eligible new Kentuckians, ongoing computer system glitches persists which erroneously deem them ineligible for Medicaid. Moreover, with a fully online enrollment system, some applications get caught in a "hard pend," stopping the process for a number of reasons that could delay enrollment for an individual or family at no fault of their own. In these situations, it is critical that Medicaid eligible Kentuckians and their providers know they'll be covered without being faced with the decision of incurring crippling medical debt or going without care entirely.

The proposed open enrollment period will further reduce access to care by eliminating passive enrollment and introducing a six-month lock-out period for those who don't complete their annual redetermination within a 6-month window. No other state has implemented lockouts for failure to enroll according to requirements. To do so in concert with removing passive enrollment intentionally creates more work and more opportunities for an individual to fall through the cracks. It is important to recognize that some Medicaid members will not be aware that their coverage has expired until they seek care. This could be due to the fact that many don't have a regular address at which they receive mail or are unable to understand the notices they receive.

Furthermore, eliminating passive enrollment will put more burden on the already understaffed and budget-strapped Department for Community Based Services (DCBS). Currently, kynectors carry a significant load of enrollment and renewal volume and provide in-person assistance to those who often need it the most. Without knowing whether these kynectors will continue to be funded by the state and in what capacity, it is unwise to place more burden on DCBS and consequently provide less enrollment assistance to Medicaid members, while imposing new requirements that wield such drastic penalties. For these reasons, it seems unnecessarily harsh and counterproductive to impose a six-month lock-out.

We believe that each of these eligibility changes would greatly reduce access to care, leaving tens of thousands of Kentuckians to rely on the emergency room for acute care, while their preventive and chronic care needs go unmet entirely.

Unanswered Questions

- How were enrollment projections calculated? How many of the 86K will lose coverage because they are unable to pay premiums or keep up with various requirements vs losing coverage because their income increases?
- What is the state's plan to create more and better-paying jobs?
- How many people currently on waiver waiting lists would be affected by these changes?
- How many adults would be affected by therapy limits?
- How would the state or MCOs manage the pre-payment for those not yet determined eligible? How would this work if they were ultimately determined ineligible?
- If coverage begins on the first day of month the premium is paid, would this provide up to 30 days of retro coverage?
- If retro-eligibility is eliminated, can a Medicaid member who has been locked-out of coverage legally be charged premiums for months of service in which they did not receive Medicaid-reimbursable care?
- In the case of Kentucky's refugee-eligible populations, how would community engagement and employment requirements fit in with long-standing, federally prescribed requirements?

KENTUCKY HEALTH BENEFITS

The Kentucky HEALTH plan seeks to provide its members with a commercial health insurance experience. Those of us with commercial insurance are confounded by this goal. Commercial insurers design their products first and foremost to create profit, often at the expense of access to care and health outcomes. Kentucky HEALTH proposes to do this through benefit reductions, ER penalties and a complicated and laborious process for "earning" critical benefits. The justification for this is that Medicaid expansion benefits should align with the current Kentucky State Employees' Health Plan. However, this seems to be an arbitrary benchmark to set and does not justify a reduction in benefits. If anything, it suggests that state employees deserve better benefits.

Eliminating Benefits

Kentucky is just beginning to shake off the shameful reputation of being the most to othless state in the nation. Prior to Medicaid expansion, Kentucky was ranked 47th on a laundry list of national health measures, including the prevalence of cancer, heart disease and diabetes. With these statistics in mind, it makes no sense to reduce necessary benefits that directly prevent, diagnose and treat these conditions.

Kentucky Medicaid is far from a Cadillac plan. In fact, it only covers necessary medical services that are comparable to many of our fellow states and less generous than some. In addition, MCOs are already given too much discretion in determining what is "medically necessary", leaving some Medicaid members without sufficient access to critical services or adequate formularies. Eliminating dental care, vision care, private duty nursing and non-emergency medical transportation for some or all Medicaid members will greatly reduce access to needed care. This, in turn, will lead to poorer health outcomes for almost one-third of Kentuckians.

Dental and vision coverage, in particular, are essential benefits for adults, especially for those who have gone most of their adult lives without needed care. Regular visits to the dentist and eye doctor are an effective way to prevent and detect disease. These visits often lead to early diagnosis of certain cancers, high blood pressure, high cholesterol and diabetes. By eliminating these benefits for Medicaid expansion adults, they will be much less likely to get necessary preventive care or benefit from early detection, leading to more advanced chronic health conditions down the road. Untreated oral health and vision problems will only make it more difficult for these individuals to find and maintain gainful employment. Even more illogical is the fact that these benefits make up less than 2% of the Medicaid budget, and cutting them will result in higher costs to the state as Medicaid members delay needed care until it becomes an emergency while chronic health conditions go undetected and untreated longer.

The elimination of private duty nursing also raises significant concerns. Doing away with this benefit will have a direct and negative impact on many Medicaid members that will, again, result in more emergency care, more advanced chronic health conditions and more disabled Kentuckians being forced to leave their homes to receive care in facilities.

Finally, the elimination of non-emergency medical transportation will further exacerbate the many barriers to care this plan puts in place. Medicaid members already have to apply separately for this benefit and provide proof that they have no reliable transportation, so it is unlikely that the benefit is being misused. In addition, public transportation in Kentucky's largest cities is woefully insufficient, often requiring multiple transfers that can easily take 1-2 hours each way. For those living in rural areas, there are even fewer public transportation options, if any. Without reliable transportation, these individuals will be more likely to miss important preventive care and delay necessary acute and chronic care until it becomes an emergency. The result is simple - less access to care, reduced health outcomes, and increased cost to the system.

My Rewards Account

The Kentucky HEALTH plan proposes the creation of a My Rewards Account to allow Medicaid members to earn incentives and to buy certain healthcare benefits. While KVH supports the use of incentives to encourage healthy behaviors, there is little evidence to suggest that wellness programs in Medicaid are effective at improving health outcomes. Moreover, there is strong evidence that these programs are administratively complex and costly, with little return on investment in terms of improved health outcomes or lower cost to the system.

In addition, we view many of these "rewards" more accurately as "reverse incentives" because they are tied to penalties or the withholding of necessary benefits for not participating. For that reason, we are concerned that the My Rewards Program will primarily serve to limit access to care. Furthermore, based on our analysis of: 1) the various reward activities; 2) potential reward dollars one can earn; and 3) the cost of purchasing necessary services on a fee-for-service basis; it is clear that this program is not designed to meet even the most basic dental and vision needs, let alone the cost of over-the-counter medications or gym membership. In order to earn the majority of these rewards dollars, one would have to be unemployed, chronically ill, a smoker, and have a substance use addiction. For the vast majority of Medicaid members, this program will be overly complicated and effectively useless.

Employer Premium Assistance Program

This plan would require Kentuckians who work for the same employer for at least one year to enroll in health insurance provide by their employer, if it's offered. While we recognize that the Kentucky HEALTH plan would "wrap" necessary benefits offered under Medicaid and pay all out-of-pocket expenses after the employee meets their premium contribution, we are concerned that it will reduce continuity of care. This is especially concerning in terms of provider networks and formularies, neither of which would be "wrapped" by Kentucky HEALTH. Furthermore, employees would be required to transition from Medicaid to their employer's plan and would have to move back to Medicaid if they were to lose their job, change jobs, or if the employer no longer offered health benefits. For these reasons, enrolling in employer coverage would not be beneficial for the vast majority of Medicaid members.

Perhaps more concerning is the potential that employers may want to avoid paying their share for health insurance benefits, which would be an additional cost shifted to them by the state. This could result in employers choosing to stop offering health benefits, limiting the hours of low-income workers so they won't qualify for employer benefits, or simply employing fewer low-income workers.

Moreover, healthcare providers who serve patients that have a blend of employer-sponsored health insurance and Medicaid, will have to determine which insurer to bill, and create systems to be able to make those determinations. This will add more administrative overhead and inefficiency in delivering care.

Population Exemptions

This plan proposes certain exemptions for those considered "medically frail", pregnant woman and children. We strongly agree that pregnant women and children should be exempt from all cost-sharing requirements and benefit reductions. However, we are concerned that the exemption for those considered "medically frail" is not enough to protect people with disabilities, serious mental health disorders, complex health conditions or other impairments from the additional barriers being put in place through this new plan.

The definition of "medically frail" is vague and hard to understand, which will make it difficult to apply appropriately. The criteria are unclear, and the conditions to which they apply could fluctuate over time. Furthermore, the "medically frail" determination will only apply automatically to Medicaid members with SSDI, receiving hospice care or diagnosed with HIV/AIDS. For all other "medically frail" individuals, the determination process has not been fully defined. We assume that these Medicaid members would need to enroll in coverage in the same way as "able-bodied" members and would be subject to all of the new requirements and penalties until they are able to get the official designation of "medically frail". By that time, some individuals with severe functional limitations may have already lost their coverage.

During this application period, premiums would be difficult to collect and difficult for the members to pay. They would too easily fall into the co-pay category, which would be much more expensive, when they have not historically been paying co-pays. The individuals with severe mental illness (SMI) who would be in this category are difficult to engage and to keep on a treatment regimen, especially with regard to medications. To impose a payment burden on them will make that engagement many times more difficult. We question whether this category is necessary at all, as it seems an undue burden to impose cost-sharing on those who ostensibly would fall into that category.

Unanswered Questions

- What evidence/rationale has the state used to determine that a reduction in benefits will improve access or health outcomes?
- How were activities and reward amounts determined? Why aren't they sufficient to earn all benefits?
- What criteria will be used to determine who is "medically frail"? Who will make this determination and what will the process entail?
- How will an emergency be defined? And who will make that determination? How will the State ensure that it is objective and accurate?
- Who will determine if someone has missed too many appointments without enough notice or good cause? And what criteria will be used to make this determination?
- What happens if someone gets penalized for "inappropriate use" of the ER or a missed appointment and does not have sufficient funds in their rewards account to pay? Would there be a debt to the State or MCO?
- In terms of employer-sponsored health plans - how will the state address issues of narrow networks, limited formularies, and different appeals or prior authorization requirements?

KENTUCKY HEALTH COST-SHARING

The cost-sharing and penalties proposed in this plan would introduce significant financial barriers and administrative complexity that would result in fewer Kentuckians with coverage and reduced access to care. Ultimately, the health and economic well-being of low-income Kentuckian will suffer as a result. Effectively, this plan is imposing financial penalties on Kentuckians simply for being poor.

Member-managed Deductible Accounts

Nearly one-third of Kentucky households with family incomes under $15,000 are unbanked. Requiring monthly payments to deductible accounts will present yet another barrier for individuals and families that are already struggling.

Payments into and out of these accounts will need to be managed regularly, which will be almost impossible to do without internet access. If benefind is any indication, the amount of mail in the form of EOBs and bills will be difficult to understand and process - and that's assuming the information sent out is accurate. Any issues with the account or questions about bills and payments will need to be made during business hours, requiring time and cell phone minutes that low-income working Kentuckians simply don't have.

These accounts will be an even more significant impediment to those considered "medically frail", who may not have the capacity to manage an account. This also threatens to undo the significant progress Kentucky has recently made in covering adults who are experiencing homelessness or re-entering society from incarceration. Many do not have regular addresses or resources to manage these accounts.

Additionally, we know from the experience of other states that HSA accounts for the Medicaid population cost much more to administer than they collect. If each MCO is responsible for managing these accounts separately, there will also be significant variation that will make them that much more complicated to understand and use. Providers, too, could be penalized through this process, if payments must be initiated by members.

Emergency Room Penalties

The penalties proposed for non-emergency use of the ER of $20 - $75 per visit are extreme in comparison to the $8 maximum currently allowed under federal regulations. There is also no clear definition of an emergency vs non-emergency. For instance, it is not uncommon for someone to think they are having a heart attack when, in fact, they are having indigestion or experiencing extreme anxiety. Likewise, it often comes down to a person's own judgement and health literacy level when deciding whether or not to go to the ER for a high fever or allergy attack. And where will Medicaid expansion members go for a painful oral infection if they haven't been able to earn enough for a dental visit or can't get an appointment in their area? For all of these reasons, we worry that Medicaid members will be penalized for using the ER when it was an appropriate choice. Or, more troubling, that someone may avoid using the ER even when it's truly needed.

Premium Contributions & Co-pays

This plan proposes premiums of $1 - $37.50 for individuals with incomes from 0% - 138% FPL. For those over 100% FPL, failure to pay your premium can keep you from ever being enrolled in coverage or could mean that you get locked out for six months. For many, these premium payments will simply be unaffordable. This is especially true for those individuals, like farmers, who have fluctuating incomes and never know how much they'll earn in a given month. Healthy members, in particular, will be forced to choose at the end of the month whether to pay their electricity bill, put food on the table, or pay their Medicaid premium. If they are healthy at the moment, the rational choice will be to take care of other, more urgent necessities.

The co-pays proposed for Medicaid members with incomes of 100% FPL and below will effectively be a lock-out for many. For those without cash on hand, it will mean delaying needed acute and chronic care, which could end up leading to more serious health problems and the use of urgent or emergency care that could have been avoided.

For those who need regular prescriptions, specialty care, therapy, hospitalization or chronic care management, the potential for delayed care could be disastrous. This will force many of the most vulnerable "medically frail" and chronically ill to pick and choose which prescriptions they can afford and to go longer between appointments or treatments than their provider recommends. For those who do continue to seek services, co-pays will quickly add up to more than the premium payments and could easily reach 2% of income. It is unclear in this plan how the state will determine when someone has met the 2% cap and will no longer be charged co-pays.

We know from our own experience that enrollment dropped when premiums were instituted in Kentucky's CHIP program. Similar efforts to implement cost-sharing in five other states resulted in marked decreases in enrollment and more churn on and off coverage. While Indiana's HIP 2.0 demonstration is still in the early phases, there have already been reports that upwards of 30% of plan members are unable to make their monthly premium payments, even with the assistance of third parties.

Finally, imposing escalating premiums on Medicaid members with incomes over 100% FPL who have been enrolled in coverage for at least two years is nothing more than a penalty for making poverty-level

wages. In most parts of the state, the majority of low-income Kentuckians have few options for making higher wages or accessing affordable benefits. While we share the Governor's goal of helping low-income Kentuckians to become more self-sufficient, we believe education and economic development are called for, not healthcare penalties. This plan will penalize low-income workers. The goal of this waiver shouldn't be to move Medicaid members onto commercial insurance. It should be to improve the health of low income Kentuckians. To improve their economic status, we need to increase the minimum wage and create better jobs in Kentucky.

Non-payment Penalties & Early Re-entry

There is no doubt that a six-month lock-out for failing to pay premiums or re-enroll on time will leave many low-income Kentuckians without coverage for significant periods of time. As mentioned already, Governor Pence reported to the Indianapolis Star in February of this year that approximately 70% of HIP 2.0 members are paying premiums. What this tells us is that almost one in three are not able to do so, despite the fact that third party payers are able to contribute premiums on behalf of Medicaid members.

The proposed "on-ramps" are no more realistic than the premiums or work and volunteer requirements. If someone cannot pay their premiums on a regular monthly basis, it is hard to imagine that they could pay back-premiums, the current month's premium and participate in a class that may take them away from work or require transportation that they don't have.

The reality for public safety-net programs is that if a Medicaid member is locked-out and is being treated for a serious condition, the provider will likely continue care due to legal, moral, and ethical obligations. And they will be doing so without any reimbursement for care provided. State general fund dollars to support this indigent care were largely eliminated from the State budget when Medicaid expansion went into effect.

For these reasons, it would be irresponsible for Kentucky to impose penalties that are certain to reduce coverage. To improve health, continuity of care is critical. Preserving access to care by ensuring uninterrupted coverage should be a priority.

Cost-sharing Exemptions

We strongly agree with the proposed cost-sharing exemptions for pregnant women and children. However, we strongly urge the Administration to exempt all Medicaid recipients from cost-sharing, as there is no evidence that cost-sharing or penalties improve access to care or health outcomes.

For Medicaid members subject to cost-sharing, reduced benefits and ER penalties, these barriers may be discouraging enough that some may decide it would be more cost-effective to be uninsured, especially if they are relatively healthy members who don't seek regular care. If fewer Medicaid members see the value in keeping their coverage, they will continue to seek care in emergency rooms, when needed, but will not receive regular preventive or chronic care. This would be another lost opportunity for Kentucky to improve the health of our population.

Unanswered Questions

- How will the State ensure that co-pays don't exceed 2% and 5% caps of total income?
- Is there a family plan option or is cost-sharing always based on individuals?
- How will the State ensure that the cost of Medicaid coverage will never be more than a subsidized QHP plan for someone with an income of 139% FPL?

KENTUCKY HEALTH DELIVERY SYSTEM & MANAGED CARE REFORMS

Delivery System Reforms

This plan proposes delivery system reforms to improve quality and outcomes. In particular, we appreciate the Administration's expressed interest in improving data collection and interoperability efforts. We agree strongly that meaningful data is a key to understanding Kentucky's greatest health challenges and creating targeted solutions to improve health. We strongly urge the Administration to continue developing the Kentucky Health Data Trust to include claims, clinical and population health data. Moreover, we request that Kentucky HEALTH include a public dashboard that can be used to set baselines and track progress to determine how and whether the improved changes are moving the needle on Kentucky's health.

We are also pleased that the plan proposes the continuation of important public health and chronic disease management initiatives. However, it is unclear how chronic disease management would *increase* as a result of this plan. MCO budgets were recently cut by 4%, with additional cuts anticipated in the near future. In addition, there have been significant budget cuts for the State Department of Public Health. While efficiencies are important, it is unrealistic to expect that health plans and public health departments can continue to do more with less. Especially in light of the fact that this plan will require a significant investment – presumably on the part of the MCOs – in infrastructure and staffing to build and support the additional administratively complex systems needed for managing premiums and deductibles, tracking activities and benefits, and closely monitoring utilization.

We appreciate that the Administration recognizes that opioid abuse is one of the most critical public health epidemics facing Kentucky. We support the proposed IMD exclusion to afford more inpatient and residential care and urge the Administration to make clear that those with a dual diagnosis of SUD and mental illness (MI) will be included. Maintaining SUD services and expanding services to Kentuckians with SUD and co-occurring mental illness should be a priority.

However, we remain very concerned that numerous financial and administrative barriers to care proposed in this plan will make it nearly impossible for Medicaid members struggling with an opioid addiction to maintain their coverage in order to receive the necessary substance use treatment over a period of time. In addition, dental pain is known to be the leading gateway to opioid addiction, making it all the more irresponsible to remove dental coverage from the basic benefit package. If Kentuckians are left to rely on the ER as their only source of dental care, it would *increase* the likelihood that more low-income Kentuckians fall into the grasp of addiction.

Managed Care Reforms

We appreciate the proposed MCO reforms, including uniform credentialing as well as consistency of formularies, prior authorization policies and forms. Since managed care was implemented in 2011, providers have struggled to manage the administrative burden of working with multiple MCOs that have different policies and processes. We also agree that there is a need to revise MCO contracts to better manage costs, increase access to care and drive improved health outcomes. However, it is important to note that these changes can be accomplished without a waiver.

Additionally, we are concerned that the Administration's goal of controlling costs will undermine any proposed improvements in access and health outcomes. Revising contracts to control costs while requiring more spending on medical benefits is incompatible with the proposed changes in this plan. MCOs are being paid less to build, manage and staff new systems. That can only mean that spending on direct healthcare services will suffer.

Moreover, the proposed MCO "payment incentives" for quality are described as a withhold. If there's no additional funding for quality, one simply cannot expect to get more for less. A withhold alone is not a value-based incentive – it's a penalty. And these are on top of the current budget cuts to the MCOs that will be going up to 8% with the new contract in 2017.

Provider bonuses – while appreciated – are not the ideal way to incentivize value. This is because bonuses are not reliable income that be can budgeted for and anticipated. Therefore, they cannot be used to support the necessary investment in infrastructure and transformation activities (data collection and analysis, care coordination, etc.) that are required to improve health outcomes. Value-driven payment must incorporate the true cost of providing better care with upfront investment.

Finally, we are concerned that this plan states that MCOs will no longer be able to waive co-pays. This could significantly reduce access to care for the most vulnerable Medicaid members - those with incomes below 100% FPL or waiting to be determined "medically frail". If they are unable to pay premiums, it is unlikely that they will be able to afford the HIGHER cost of co-pays. If co-pays are required, providers will be forced to turn patients away or provide uncompensated care.

Unanswered Questions

- How will these deductible account and My Rewards account be designed? Who will pay for them and manage them? How will they be integrated with each other and benefind?
- How will the current public health system address chronic health within its current underfunded budget and outdated infrastructure?

IMPLEMENTATION OF DEMONSTRATION & EVALUATION PLAN

Kentucky HEALTH Implementation

This plan proposes a phased implementation throughout different regions of Kentucky. We agree that a phased approach is best when making such immense changes. However, the proposed timeline would have implementation beginning six months following approval of the waiver. This seems extremely ambitious and much too short. During this time, MCO contracts would need to be renegotiated and sophisticated new systems would need to be designed and tested. Most importantly, a great deal of patient and provider education would have to be designed and implemented.

This plan will require Medicaid members to use no less than THREE separate accounts - benefind, My Rewards, and an HSA. That is more than any commercial health insurance plan we are aware of. This will introduce not only a significant amount of confusion and complexity to the system, but opportunities for system errors that could lead to lost "rewards", lock-out, or disenrollment.

With the complicated transition already taking place as kynect is being dismantled, we would also caution the Administration that an additional transition - especially one with so much administrative complexity - could cause significant disruption of coverage and access to care. We are concerned that many Medicaid members – in particular those considered "medically frail" or waiting for that determination – could fall through the gaps.

Kentucky HEALTH Evaluation Plan

The proposed evaluation plan includes a number of important measures, however, they are heavily focused on cost and utilization. In order to determine if Kentucky HEALTH is meeting the criteria set

forth by HHS for this demonstration, measures must be included to track access to care, utilization and patient experience.
In addition, we urge that the following recommendations be adopted for the implementation and evaluation of Kentucky HEALTH:

1. Provide a rationale for each element of the proposal based on the "triple aim" of improving patient experience, improving population health and better managing cost. Conduct a cost-effectiveness analysis of each waiver element to determine if it increases access, improves health, and lowers or maintains administrative cost.
2. Establish and empower a governance structure with multi-stakeholder representation, including advocates and consumers. Ensure meaningful stakeholder participation in decision-making and oversight.
3. Ensure transparency throughout the development, implementation and evaluation of the waiver. Create a dashboard, updated monthly, that contains implementation and evaluation data to be shared with the governance body at regular stakeholder meetings and with the public.
4. Conduct rigorous evaluation using a third-party evaluator selected by the governance body.

Unanswered Questions

- How will communities be assessed to determine whether they will have the necessary infrastructure and resources for community engagement, work requirements and education classes? And what will be done to assist communities that don't?
- How will the state ensure that no one loses coverage due to system failures?
- What is the timeline for amending the state plan? Will the state take public comments into account when making these amendments?

DEMONSTRATION OF FINANCING & BUDGET NEUTRALITY

According to the Kentucky Center for Economic Policy, the Medicaid waiver proposal claims the changes will save $2.2 billion in federal and state money over the first 5 years of the program. But the waiver document shows those savings would occur because fewer Kentuckians are covered. The data provided shows thousands fewer Kentuckians will be covered by Medicaid in the first year of the demonstration compared to not having the waiver, a number that would grow to nearly 88,000 in year five.

Other elements of the waiver don't explain the projected cost savings because the estimated cost per member, per month is actually higher for the Medicaid expansion population under the waiver, though it is slightly lower for children and non-expansion adults.

Evidence does not support that the waiver will result in members' incomes increasing such that they are no longer Medicaid eligible. The administration suggests coverage reduction will happen in part because they will move people to private insurance plans; in addition, their incomes would need to rise above 138 percent of poverty so that they are no longer eligible for either regular Medicaid or premium assistance and wrap-around coverage. But it is unclear what evidence is being used to connect the assumed increase in economic well-being to the measures and requirements included in the plan. The assumption that promoting work will somehow lead to this outcome is at odds with the research on work requirements and the reality that the majority of those who have gotten coverage from the Medicaid expansion are working now; they just work in jobs where they cannot afford or are not offered coverage. Many workers are Medicaid recipients because a large portion of jobs pay low wages while wage growth has been stagnant, and because rising healthcare costs over the last few decades have led

employers to shed responsibility for coverage. Whereas 70 percent of Kentucky workers had employer-based coverage in 1980, only 56 percent do today. Even if the minority who are not working were to suddenly gain employment — which evidence does not support would result from these requirements — it should not be expected that many would obtain jobs that lift them above 138 percent of the federal poverty level.

The services being used by the expansion population are, for the most part, not the services that drive overall Medicaid spending. These enrollees are relatively inexpensive to cover and the coverage allows them to maintain health and continue working and caring for their families. And when a screening does indicate cancer or diabetes, it is still money well-spent. Left undiagnosed or untreated, these conditions worsen and become more complicated (and expensive) to treat later on. Kentucky's current Medicaid program also has a positive impact on Kentucky's economy, an impact that this waiver would put in jeopardy. For example, the General Fund savings Kentucky will realize because of Medicaid expansion in 2017 and 2018 from spending on public health, mental health, indigent care and other areas surpasses what the state will have to put in to match the federal investment. Even when 10 percent of the cost must be covered by the state beginning in 2020, the return on the state's net contribution will be large after taking into account these savings, the additional tax revenue resulting from job creation due to the injection of federal dollars and the health benefits for our communities and workforce.

Finally, it is clear from the Kentucky HEALTH proposal that this plan requires significant investment in infrastructure (creating deductible and "my rewards" accounts that integrate with each other and benefind and are easily transferrable between MCOs), administrative oversight (creating an eligibility determination process for the "medically frail"; tracking work, volunteer, health behavior and education activities), and additional complexity for Medicaid members, providers, nonprofit organizations used for volunteer requirements, MCOs and the State. What is unclear, is the full cost of building and maintaining this additional infrastructure and additional administrative personnel for both the MCOs and the State. Also unclear is the cost shifting that will occur to: 1) providers required to provide more uncompensated care in addition to the increased administrative hassles of determining who is eligible for what services and whether Medicaid or an employer plan should be billed; and 2) nonprofits that will be required to run background checks, provide training and supervision, and be responsible for tracking and reporting requirements. These costs should be included in a full cost-effectiveness analysis of this plan and measured against the 1115 Waiver criteria for increased efficiencies, greater access, and better health outcomes.

There are better ways to make Kentucky's Medicaid program more sustainable that would not require a waiver. In many states, hospitals have offered or been agreeable to an increase in the provider tax to help fund Medicaid expansion. Currently, Kentucky's provider tax on hospitals has been frozen at 2006 revenues. By simply lifting the cap, the State could bring in approximately $100 million more in tax revenue based on FY15. Additionally, by implementing a statewide comprehensive smoke-free law and/or raising the tobacco tax, Kentucky could drive down smoking rates, saving tens of millions in direct Medicaid costs alone.

Unanswered Questions

- Were expansion savings and revenue included in this analysis?
- How many of the 86K Medicaid members are projected to lose coverage due to inability to pay or meet requirements?
- Are increased administrative costs included in this analysis?
- Of the additional administrative costs, which will be the responsibility of the State and which will be the responsibility of the MCOs?

STATE COMMENT PERIOD

The Kentucky Equal Justice Center conducted a thorough review of the public notice and public hearing process. They found that, despite Governor Bevin's assurance of "taking every step to ensure the process of applying for a Section 1115 Demonstration Waiver is open and accessible to the public," the public hearings did not meet the standards set out in 42 CFR 431.408.

Federal regulation require "postal and Internet email addresses where written comments may be sent and reviewed by the public." The administration has provided postal and email addresses where written comments may be sent, but no meaningful ability to review public comments. Legislators at the Task Force on Vulnerable Kentuckians hearing in Beattyville, Kentucky commented how easy it is to make comments online, but there was no way to submit comments others could read on this Application.

What the administration did provide, on the Cabinet for Health and Family Services' website, in line with the Frequently Asked Questions, overview, and formal public notice documents, is "Kentucky HEALTH Waiver Praise". Describing the public comments from the hearings as praise is disingenuous. It is not transparent, and a directly misleading representation of the comments at the public hearings. Not one person spoke in support of the substance of the Application at the first hearing, and the trend continued at all three. No corresponding document of Kentucky HEALTH Criticism or even a more neutral document was added.

The "Praise" document was available at the same time the Application became available to the public, which means the "praise" either was from parties who had not seen the Application, or from parties with access to the Application prior to the public, which would exclude those comments from the "public comment" category.

At the public hearings, the administration made comments that led advocates to believe public comments submitted via the process announced in the Kentucky HEALTH Formal Public Notice and website would never be available for the public to review and moved Kentucky Voices for Health to create an alternate email address to use to collect public comments.

Gov. Bevin did hold "two public hearings in geographically distinct areas of the State", but none were in a high population center. Kentucky is a rural state, and has only two cities with populations over 70,000, Lexington and Louisville. No public hearings were held in Lexington or Louisville. Requests were made by Kentuckians at the public hearing in Frankfort and Hazard to host public hearings in other regions of the Commonwealth, specifically Lexington, Louisville, Northern Kentucky, and somewhere in Western Kentucky. After the Governor's proposal was announced and released on June 22, there were only three business days before the first public hearing in Bowling Green. The room was full, and no one made any positive comments about the proposal, but many more people had anticipated being able to participate via a live stream. There was a live stream, but it did not have any audio for a significant portion of the hearing, and poor audio throughout. The overall quality was so poor that live streaming the hearing from a cell phone via Periscope was an improvement that prompted public thanks from Kentuckians trying to watch remotely. The ability to hear in the room was not much better, noted by the "Female Audience Participant: I'm so sorry. There's so much noise to follow you in the back of the room. I can't hear anything." followed by the reporter also announcing she was unable to hear Mr. Adam Meier. Even after complaint, the sound in the room was not corrected.

At the second public hearing, the next day, June 29th, less than a week after the announcement of the proposal for Medicaid Transformation in Kentucky, the disingenuous nature of the public comment process was more pronounced. The public hearing was scheduled from 1pm to 3pm. There was no live

stream. Not only was the hearing room with seating for between 100-200 people overflowing, the overflow room with the hearing on screens was overflowing. People were sitting on the floor and standing in the hallway at 1pm waiting to speak. Not one member of the public was allowed to speak between 1pm and 2:30pm. It was not until around 2:35, ninety five minutes into a scheduled period with only twenty five more, were the first members of the public invited to speak and comment. People were outraged and shouting at the delay. People who had come to Frankfort to be able to make a comment left before their names were called. The perception in the room was that the administration did not want the public to speak and were filling as much of the scheduled two hours as possible to prevent more public comment. The administration did stay in the room past 3pm, but many of the Kentuckians who had come to share their concern were unable to stay, and others did not trust that the administration would extend the hearing, based on the experience thus far.

Since the initial state comment period ended on July 22nd and was then re-opened on August 5th and ran through August 14th, additional evidence was released that will be relevant to the upcoming negotiations between HHS and Kentucky on this proposed plan.

JAMA Study Finds Improved Health Outcomes and Better Access to Care

Additional evidence of the positive impact Medicaid expansion is having in Kentucky was revealed by a recent study published in the Journal of the American Medical Association (JAMA). Interviews conducted over three-years compared the health and economic wellbeing of more than 9000 low-income residents in Texas, Arkansas and Kentucky. Researchers found that, "By 2015, two years after coverage expansion, low-income adults in Kentucky and Arkansas received more primary and preventive care, visited emergency departments less often, and reported better health than their counterparts in Texas." The Commonwealth Institute summarized these findings, as follows:

- Between 2013 and 2015, there were dramatic drops in the uninsured rates in both Arkansas (41.8% to 14.2%) and Kentucky (40.2% to 8.6%), but much smaller changes in Texas (38.5% to 31.8%).
- In Arkansas and Kentucky, having coverage was associated with a significant increase in the likelihood of having a personal physician (12.1 percentage points) and a decreased reliance on the emergency department as a usual source of care (–6.1 points).
- Expanded coverage also was associated with fewer delays obtaining care because of cost (–18.2 points), fewer skipped prescriptions (–11.6 points), and less difficulty paying medical bills (–14.0 points). Annual out-of-pocket medical spending dropped by 29.5 percent.
- Expanded coverage in the two states also led to an increased likelihood of having a check up (16.1 points) and a glucose check (6.3 points) in the past year. Diabetics had an increased likelihood of glucose monitoring (10.7 points).
- Compared with Texas, the share of adults receiving regular care for chronic conditions increased 12.0 points, the share of adults reporting fair or poor quality of care declined 7.1 points, and the proportion reporting excellent health increased 4.8 points.
- Arkansas' coverage gains were primarily through private insurance, and Kentucky's were through Medicaid. While changes in glucose monitoring were larger in Kentucky than in Arkansas, none of the other 26 outcomes differed significantly between the two states.

These findings prove that Medicaid expansion has indeed moved the needle on Kentucky's health. Not only are Kentuckians experiencing major gains in coverage and access to care, but improved health outcomes, as well.

Healthy Indiana Plan 2.0 Evaluation

On July 6th, an interim evaluation report of Indiana's HIP 2.0 plan was published. This report reveals a

number of troubling findings, including a decrease in enrollment and more barriers to care. This evaluation reinforces what ample research has already found. Namely that cost-sharing and administrative complexity reduce coverage and access to care.

Shortly after the evaluation results were released publicly, a letter was issued by CMS on July 29th in response to requests made by Indiana to implement a new lock-out period and extend the waiver of retro-active eligibility. The letter expressed concerns about these initial findings and cited the evaluation as a primary reason that CMS chose to deny Indiana's requests. Additionally, CMS stated clearly that the proposed lock-out period was inconsistent with the objectives of the Medicaid program and could not be approved.

These findings, along with CMS's recent decisions, further indicate that Kentucky's waiver proposal cannot be approved.

Concerns about the Extended State Comment Period

The way in which the state comment period has been conducted is concerning to us on a number of fronts. This comment period was flawed from the outset when Governor Bevin unveiled Kentucky HEALTH with the threat that he would repeal expanded coverage for nearly half a million Kentuckians if his plan is not approved. As a result, we believe that many stakeholders have chosen not to comment or to moderate their comments based on this threat. Despite this, stakeholders who did respond during the original comment period were overwhelmingly opposed to the plan.

Following the July 22nd deadline, we were informed that the Administration received a much higher volume of comments than anticipated, making it necessary to push back the timeline for submitting a final waiver proposal to CMS. For this reason, we were surprised that the Administration decided to re-open the state comment period three weeks later.

The state comment period was re-opened on August 5th, citing a new deadline of August 12th. This was done by adding one sentence to the Kentucky HEALTH website, which was located near the bottom of the page, *well below* the original deadline, which still cited July 22nd when it was noticed on August 8th.

It is unclear whether the Administration had any plans to make a public announcement, which it typically does through a press release issued by the Governor's office or CHFS. KVH reached out to Administration officials upon learning of this new comment period on August 8th and was told that the Administration had tried to get information in the Sunday (8/7) news, but could not. Therefore, the plan was to run the public notice in the news on Thursday (8/11), one day before the comment period was scheduled to end. KVH then learned from a number of media sources that they were unaware of the new deadline and had not been contacted by the Administration. Upon reaching out, reporters were told that the comment deadline had been extended again to August 14th. The website was not updated until Tuesday, after KVH mentioned this oversight to the Administration twice on Monday. No press release was ever issued to our knowledge.

This strikes us ineffective at best and antithetical to the purpose of having a public comment period. While presented as an additional opportunity to comment, members of the public – and even those of

us who are following this process closely – were completely unaware and therefore, unable to take advantage of the additional time.

For these reasons, we are left with a number of questions:

- Why did the Administration decide to re-open the comment period?
- When was this decision made and why was there no effort to issue a press release or spread the word through other public channels?
- Were any groups or individuals alerted to the new deadline before August 8th? If so, who was alerted and why?
- Will any of the comments submitted to the state be shared publicly or with HHS during negotiations?

FEDERAL COMMENT PERIOD

In response to the flawed nature of the state comment period and the fact that nearly 1.2 MILLION Kentuckians would be directly affected by these proposed changes, KVH and our Keep Kentucky Covered campaign partners decided to reach out to Kentuckians to collect their input and provide them with a voice in the public comment process by conducting an online survey. We heard back from more than 700 of them during the state comment period alone and well over 500 more during the federal comment period. We asked them to tell us how the proposed changes would affect themselves, their families and their communities. The response was enormous. In no uncertain terms, Kentuckians told us that Medicaid coverage has been good for the health of Kentucky, has kept them out of bankruptcy, has made it possible for them to work and study, and SAVES LIVES. They also shared their concerns. That their health would deteriorate, that they would no longer be able to receive life-saving treatment, that they would be unable to navigate confusing changes and program requirements, that work and volunteer requirements would worsen the stigma that low-income Kentuckians already bear.

Attached to our comments, we are sharing a full survey report that reflects the opinion of Kentuckians, including those who would be directly impacted by these changes as well as many who are concerned about the impact for their communities.

During the federal comment period the Keep Kentucky Covered campaign, led by KVH, hosted a series of eight community forums throughout the Commonwealth to educate Kentuckians about the proposed changes and provide an opportunity for community members to raise their voices. These forums reached from Paducah in far Western Kentucky to Prestonsburg in Appalachia, while also hitting each of the high population areas of the state, including Louisville, Lexington and Covington. Each forum drew a wide range of community members, including private citizens, providers, business leaders and legislators. At each, Kentuckians shared their questions, concerns and outrage for the changes being proposed. They shared powerful testimony about the ways in which coverage has benefited themselves, their families and their communities and their fears about the impact of the proposed changes. A retired doctor in Morehead expressed concern that their hospital could close. Entrepreneurs in Paducah and London pointed to themselves indicating that "this is what Medicaid looks like." An LCSW described how people with mental illness were better off since Medicaid expansion, with fewer being sent to the state-run hospital as a last resort. Testimony from these individuals, as well as dozens more, will be shared

separately with HHS, in additional to written comments KVH collected from more than a thousand Medicaid members, family members, providers, and concerned citizens.

Negotiating a Final Plan for HHS Approval

We submit these comments with the hope that HHS and Governor Bevin listen closely to the needs and concerns of Kentuckians and work collaboratively with stakeholders to design a final proposal that will truly move Kentucky's health, economy and quality of life forward.

To that end, KVH convened a Waiver Task Force to identify potential opportunities and challenges a waiver would present for Kentucky's Medicaid program. This work resulted in a paper that offers principles to guide the design of a waiver and makes recommendations for waiver provisions that would improve health and manage cost without creating barriers to care. The full set of recommendations are attached.

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Attachment I: Survey Results re: Governor Bevin's Proposed Medicaid Changes

	Yes	No	Total
Do you think Kentucky should keep Medicaid expansion the way it is now, without changes?	1036	227	1263
Do you think it's a good idea to require Medicaid members to manage 3 separate accounts to keep their coverage?	10	1134	1154
Charging premiums	326	937	1263
Charging co-pays for Medicaid members who are unable to pay their premiums	199	1064	1263
Enforcing a 6-month lock-out from coverage as a penalty for not paying premiums or re-enrolling on time.	155	1108	1263
Penalties for non-emergency use of the ER	447	812	1259
Requiring workers to enroll in their employer's health insurance, rather than keep their Medicaid coverage?	403	856	1259
Removing dental and vision care coverage from the basic benefit package for Medicaid expansion members?	107	1155	1262
Requiring these individuals to use a "rewards account" to earn back vision and dental benefits?	220	1039	1259
Requiring individuals to volunteer or participate in "work activities" to keep or earn Medicaid coverage?	355	908	1263
Eliminating "retro-active eligibility" coverage for Medicaid members who are eligible, but not enrolled?	150	1107	1257
Eliminating transportation assistance for necessary medical care?	144	1117	1261

Attachment II: Recommendations to Transform Kentucky's Medicaid Program

"Kentucky's Medicaid expansion has led to one of the biggest reductions of uninsured people in America, and any changes to the program should maintain or build on the historic improvements Kentucky has seen in access to coverage, access to care, and financial security."

— Ben Wakana, U.S. Department of Health and Human Services

Governor Matt Bevin plans to propose a Section 1115 Medicaid waiver to reshape Kentucky's Medicaid program. Governor Bevin says changes will improve health outcomes while making Kentucky's Medicaid expansion financially sustainable.

This paper describes the opportunities presented by Section 1115 waivers, as well as existing regulatory flexibility in the Medicaid program, to build on the foundation of Medicaid expansion. It offers principles to guide the waiver design. Most importantly, it makes recommendations for waiver provisions that would improve health and manage cost without creating barriers to care.

The KVH Waiver Task Force

Kentucky Voices for Health (KVH) is a nonpartisan coalition. It brings together consumers, advocates and stakeholders from multiple sectors of Kentucky's healthcare landscape. KVH convened a Waiver Task Force to study whether—and how—a Section 1115 waiver could be used to improve health. Task Force recommendations were informed by:

- conversations with advocates in states that are already using 1115 waivers[1]
- an analysis by the State Health Access Data Assistance Center of five existing waivers[2]
- multi-stakeholder input collected by the Foundation for a Health Kentucky at a recent convening[3]
- a report from the Kentucky Center for Economic Policy on Medicaid's role in advancing the health of Kentucky[4]

Top Task Force recommendations include: engaging consumers in their care, fostering delivery system pilots, focusing care coordination on hot spots and high use, building Kentucky's Health Data Trust, and protecting medically fragile Kentuckians from cost-sharing.

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[1] Arkansas, Indiana, Virginia, Montana

[2] State Health Access Data Assistance Center (May 9, 2016). Section 1115 Waivers and ACA Medicaid Expansions: A Review of Policies and Evidence from Five States. Retrieved from http://www.healthy-ky.org/sites/default/files/1115%20BRIEF%20FINAL%205-9-16.pdf

[3] The Foundation for a Healthy Kentucky (May 2016). Medicaid Waiver Stakeholder Convening; Stakeholder Input Report. Retrieved from: http://www.healthy-ky.org/sites/default/files/1115%20waiver%20report%20May%2025%20FINAL.pdf

[4] Cobb, M. (2016, May 16). Protecting Medicaid's Role in Advancing a Healthy Kentucky - KY Policy. Retrieved May 24, 2016, from http://kypolicy.org/protecting-medicaids-role-in-advancing-a-healthy-kentucky/

Section 1115

Section 1115 of the Social Security Act permits the U.S. Department of Health and Human Services (DHHS) to waive some requirements of the Medicaid program. The purpose is to allow states to conduct demonstration projects. Projects must promote the objectives of Medicaid and the Children's Health Insurance Program. They must cost no more than the state would have spent without them.

Section 1115 requires publication of state waiver proposals for public comment both before and after submission to DHHS. The federal agency will review to see whether a proposed waiver project will:

- increase and strengthen overall coverage of low-income individuals in the state;
- increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- improve health outcomes for Medicaid and other low-income populations; and/or
- increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Cost savings alone are not a sufficient basis for a waiver.

The KVH Waiver Task Force Principles

The Waiver Task Force adopted guiding principles to evaluate the proposed elements of Kentucky's demonstration project. Based on the Institute for Healthcare Improvement's "Triple Aim"[5] and Families USA's principles for positive health system transformation[6], the Task Force calls on state leadership and Kentucky's healthcare stakeholders to:

- Provide the right care, in the right setting, at the right time
- Invest in the things that keep people healthy
- Pay providers for better outcomes, not higher volume of care
- Reduce health disparities by addressing the social determinants of health

The Task Force viewed coverage as the essential *foundation* for better care, better outcomes and better management of cost. It viewed availability and transparency of data as the key to understanding impact. The first set of recommendations below addresses costs and care. The second addresses the waiver process itself, including evaluation.

[5] Brooks, K. (2016). The IHI Triple Aim. Retrieved May 24, 2016, from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

[6] Hernandez-Cancio, S., Mitts, L., & Morris, C. (February 2016). Guiding Principles for Consumer-Friendly Health System Transformation. Retrieved from: http://familiesusa.org/sites/default/files/product_documents/HST_Principles_web.pdf

Recommendations for Better Care, Improved Outcomes and Sustainability

The Task Force recommends strategies and programs that would:

1. Test models of care delivery and payment redesign to improve health outcomes and reduce health disparities
   → *Establish a community innovation fund to give providers the flexibility to pilot new models of care in collaboration with community-based partners*
   → *Reinvest savings generated by the waiver in system transformation to create a more durable infrastructure for better care that will have a lasting benefit for Kentuckians*
2. Support whole-person, patient-centered care that addresses the needs of vulnerable populations
   → *Create care coordination and case management benefits for high utilizers and high-need populations*
   → *Promote cultural competency, language access and equitable access to care -- especially for people with physical and behavioral challenges*
   → *Remove administrative barriers to integrated care*
   → *Strengthen support services such as peer support, community-based services, housing, and transportation*
   → *Encourage healthy behaviors with evidence-based strategies that use incentives, not penalties*
3. Establish a Community Health Worker program to:
   → *Serve as a link between healthcare, social services and the community*
   → *Improve the quality and cultural competence of service delivery*
   → *Build individual and community capacity by increasing health knowledge and self-sufficiency*
4. Further develop the Kentucky Health Information Exchange and Kentucky Health Data Trust to allow providers and policy makers to:
   → *Manage care, reduce unnecessary utilization and measure health outcomes*
   → *understand utilization patterns and identify population health trends*
   → *Inform the waiver evaluation*
   → *Empower consumers to access their personal health information and to view provider and hospital quality indicators*
5. Ensure barrier-free access to medically necessary services and medications
   → *Maintain the current range and level of benefits for all Medicaid recipients*
   → *Maintain Kentucky's current level of cost-sharing with no premiums or additional co-pays*
   → *Establish a "medically fragile" category for people with chronic conditions, dual diagnoses and serious mental illness and exempt them from cost-sharing requirements*
6. Improve access by using multiple strategies to promote the "right care, right setting, right time"
   → *Increase provider reimbursement*
   → *Invest in workforce development*
   → *Strengthen network adequacy requirements for managed care organizations*
7. Reduce the complexity and cost of managed care
   → *Align benefits and formularies*
   → *Streamline current administrative processes*
   → *Ensure any new requirements or programs will decrease administrative burden for the state, MCOs, and providers*

Recommendations for Ensuring an Effective Demonstration Process

The Task Force recommends a waiver proposal and process that would:

1. Provide a rationale for each element of the proposal based on the "triple aim" of improving patient experience, improving population health and better managing cost. Conduct a cost-effectiveness analysis of each waiver element to determine if it increases access, improves health, and lowers or maintains administrative cost.
2. Establish and empower a governance structure with multi-stakeholder representation, including advocates and consumers. Ensure meaningful stakeholder participation in decision-making and oversight.
3. Ensure transparency throughout the development, implementation and evaluation of the waiver. Create a dashboard, updated monthly, that contains implementation and evaluation data to be shared with the governance body at regular stakeholder meetings and with the public.
4. Conduct rigorous evaluation using a third-party evaluator selected by the governance body.

Kentucky Voices for Health (KVH) is a nonpartisan coalition that brings together consumers and stakeholders from all sectors of the health landscape to improve the health of all Kentuckians.

June 1, 2016